Ask the Experts: Individual Mandates
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LARRY LEVITT: Welcome to Ask the Experts. A regular interactive web show that provides in depth discussion of current health policy issues and allows you to interact directly with the nation's top policy experts. For the first time since the failure of the Clinton health plan over 13 years, the notion of comprehensive health reform is in the air. At the heart of many reform plans is a requirement that some or all Americans obtain health insurance.

On January 1, Massachusetts began enforcing such a mandate as part of its effort to provide universal coverage. The idea has made it into congressional legislation as well and just yesterday a major business coalition endorsed the idea. On the campaign trail candidates have sparred over individual mandates in both the Democratic and Republican presidential debates are in here in our usual too boring for C-Span approach is to bring a reasoned and analytic discussion to this very contentious issue. We are joined by three experts from across the ideological spectrum to do just that.

Michael Cannon is Director of Health Policy Studies at the Cato Institute and a former senate staffer. Sherry Glied is Chair of the Health Policy and Management Department at Columbia's Mailman School of Public Health. She previously served as a senior economist for the Council of Economic Advisors under Presidents Bush and Clinton. And Len Nichols,

on the phone with us from Denver is a health economist and Director of the Health Policy Program at the New America Foundation. He earlier served as a senior advisor for health policy at ONB. You can reach our panel of experts in two ways, e-mail your questions to ask at Kaisernetwork.org or call us here at the Kaiser Family Foundation broadcast studio and ask your question on the air. You can phone toll free at 1-888-Kaiser-8. That's 1-888-524-7378 and we'll try to get to as many of you as we can. Thanks to all of you for joining us and Len, let me start with you on the phone from Denver.

LEN NICHOLS, PH.D.: Okay.

LARRY LEVITT: I want to start with some of the factors you and others as advocates for an individual requirement or an individual mandate, point to as reasons to go in that direction. Let me start first the question of achieving universal coverage, since that's been a major point of contention on the campaign trail. IN your view is an individual mandate the only way, let's say short of a single payer approach to get to universal coverage, to guarantee universal coverage?

LEN NICHOLS, PH.D.: I think it's absolutely necessary to cover all Americans if you want to do it in a market oriented private insurance system. And you are right, the only other way is single payer. I think a lot of health economists would agree with me and the Urban Institute just released a

study today or yesterday confirming what I believe the healthcare literature is pretty clear about, the responsiveness of people to try subsidies. If you go pure voluntary even if you have fairly generous subsidies you are not going cover more than half of the uninsured. So basically the reason to do a mandate is not because we like it, I mean I would think the mandates are kind of like booster shots, they are vaccinations that sometimes hurt a little bit, but they protect you from the rest of us and they protect the rest of us from far worse illnesses down the road. They actually make markets work better to make sure everyone pays their fair share, it would reduce the severe adverse selection fear of insurers which enables you to impose rules that make markets more fair and part of the fairness rules, that is to say you can't charge people differentially based on their health status, will reduce the underwriting and selling costs that keep the cost of insurance so high and fundamentally that makes it possible to have both more efficient and more fair markets with mandates.

LARRY LEVITT: Let me ask you, you compared a mandate to a vaccination shot to protect people from an illness or a disease, what is the illness that we are preventing here. I mean, what are the consequences of having what some people would call free riders, I mean people that are outside of the system?

LEN NICHOLS, PH.D.: Well, what happens with people don't have health insurance, but they do have an emergency or a condition that reaches the level where they seek care, if they can't afford it most of our provider institutions will try to give them the care that they have available to them and they will charge the rest of us for that. So it shifts the cost on to the rest of us.

Now for the low income population, we have some programs that take care of that, but what we are trying to do with the mandate is have everyone pay their fair share, roughly 20-percent of the uninsured in our country actually make more than three times the poverty level in income. So they could surely afford to pay all if not most of an insurance premium and basically then by not requiring them to do that, the rest of us bear the cost of the uninsured.

LARRY LEVITT: You also hit on the idea of affordability as well. Explain that a little bit, is it necessary in your mind to have subsidies to make insurance more affordable going along with a mandate?

LEN NICHOLS, PH.D.: I think of mandates as part of a three pronged strategy. First, you absolutely have to make the market more organized and work better. Rules can make markets work better and you have to have subsidies for the low income. If you don't have subsidies for the low income, only a draconian tyrant would impose a mandate. So if you don't have

a willingness to subsidize the low income, you should never go down a mandate road.

What I'm so heartened by in the campaign and a larger public discussion is how many folks think it's about time we are willing to pony up and subsidize our fellow man to make our system more efficient and more fair.

LARRY LEVITT: Let me sort of, just to wrap this up. And you also talked about making markets work, so would that involve, let's say rules that would require insurers to take all comers, prohibit premium surcharges for people who are sick?

LEN NICHOLS, PH.D.: That's right, you would require them to accept all comers and that enables everyone to buy on a level playing field and, I mean in my ideal world, I would have age rating so you would charge me 50-something, a great deal more than Sherry's grad students. But I certainly think it's not smart to charge people more because of their health conditions and so you'd have something like modified community rating and that would be fundamentally essential to making the market more fair.

LARRY LEVITT: Well, Sherry looked a little worried here that you were going to compare your age to her age, I think.

LEN NICHOLS, PH.D.: Her grad students.

LARRY LEVITT: Michael Cannon, let me turn to you an opponent of mandates. The Cato Institute has in their tag line individual liberties, so I guess it's not a huge surprise that you wouldn't be enormously fond of government mandates, but getting beyond the philosophical considerations, however, important they are, let me talk about some of the more pragmatic issues you've raised and some of which you have written about how a mandate would work or some of the barriers to making a mandate work. Give us a sense of what some of those barriers are, what are some of the difficulties in implementing a mandate, or what would be some of your concerns in going that direction?

MICHAEL CANNON, M.A., J.M.: Interestingly about the philosophical point there really is, although we are opposed on philosophical grounds, there really is no difference between what say Governor Romney did in Massachusetts in terms of creating an individual mandate and what the federal government does with the tax exclusion from sponsored insurance. In both cases either you buy insurance or you pay effectively higher taxes and so you could say that that line has already been breached.

But with regard to how individual mandates would operate and what they would achieve I think there are three principal problems, one is that the problem that individual mandates report to fix is just not very big, the free rider

problem. The second problem is that an individual mandate will not get supporters where they want to go, which is to universal coverage. And third, supporters of individual mandates and universal coverage really shouldn't want that, if what they want is to improve health outcomes in the United States.

LARRY LEVITT: Let's come back to those. Take the first issue about free riders, that you say that problem is not very large. How do you define this issue of free riders? There are many definitions out there, who would constitute a free rider in a voluntary system?

MICHAEL CANNON, M.A., J.M.: I think the definition that I use is the one that John Holahan and Jack Hadley of the Urban Institute used in their recent, I think it's a year or two old, Health Affairs article on uncompensated care in the U.S. and what they found is that only 2.5-percent of health spending goes toward uncompensated care for the uninsured. So you compare that, what's essentially a 3-percent problem to the much larger problems that we have in our healthcare sector, like 30-percent of spending goes toward care that doesn't make people any healthier or happier.

I think that waste, then, is a much bigger problem than the free rider problem. Plus, even if an individual mandate did work there's another 1.2-percent of health spending that is uncompensated care that's given to people who do have health insurance. So even if an individual mandate were able to cover

everyone, even some people with health insurance don't pay their bills and so that wouldn't eliminate the free rider problem.

LARRY LEVITT: So in a sense free rider is what Len was talking about, about the hidden tax on people with insurance from having— [interposing]

MICHAEL CANNON, M.A., J.M.: Right, although that's another interesting aspect of this question. Is it a hidden tax and to what extent is our free riders a hidden tax on those with health insurance. To some extent they certainly are, those costs have to be passed on to someone, somehow. But there was an article in the most recent issue of *The Journal of Health Economics* by Jonathan Gruber, a colleague, that said that if you look at physicians and how much money they get from the uninsured and you look at how much they lose to the uninsured who don't pay and how much they make off the uninsured who do pay, because they charge the uninsured who do pay so much more than they charge private insurers, that on balance they make more off the uninsured than they do off privately insured patients, even when you include the free riders among the uninsured.

So, if someone is paying for the cost of those uninsured free riders then it seems to be the other uninsured people, the people who do pay their bills.

LARRY LEVITT: At least in the case of physicians?

MICHAEL CANNON, M.A., J.M.: In the case of physicians, yes.

LARRY LEVITT: You also said that you didn't think for someone who would aim for universal coverage that a mandate would not actually get there, why is that?

MICHAEL CANNON, M.A., J.M.: There are a number of reasons and Sherry has written a lot about these. Take what's happening in Massachusetts, a lot of people are just not going to comply with the mandate because they are ornery. Other people are going to not comply with the mandate because they can't afford it. And even in Massachusetts, one of the things that's happened in Massachusetts is that they've decided to exempt a number of Massachusetts residents from the mandate because those people can't afford it and because the state is not willing to cough up the money necessary to give them the subsidies that would allow them to afford that.

I think it's possible that an individual mandate could achieve 100-percent coverage or something very close to that. But by the time the state enacted the sorts of penalties, I should say the sorts of penalties that would be required and the higher taxes that would be required in order to subsidize people to encourage them, I don't think that there is a political will in really any of the states to support that, certainly there wasn't in California and there isn't even in Massachusetts which is a much more left leaning state.

LARRY LEVITT: And do you think, I mean you've talked about these subsidies and there are some who have advocated starting with subsidies, making coverage more affordable, see if that expands coverage to add or near universal coverage, is that an approach you would go?

MICHAEL CANNON, M.A., J.M.: I don't think so and that gets really to my second objection to individual mandates which is suppose we have given amount of money these subsidies that you are talking about and we are trying to figure out how we are going to best improve health outcomes with that money, there is no evidence and economists have looked at this, have said, there is no evidence, none, that spending that money on health insurance will get us better outcomes than spending it on nutrition education programs or clinics.

LARRY LEVITT: Better health outcomes.

MICHAEL CANNON, M.A., J.M.: Right, or other expenditures that can affect health. They even raise education as a possibility because there is such a close link between education and health outcomes. So, if we don't have any evidence that health insurance, and spending that money on health insurance is going to get us the best health outcomes and yet we've already decided that what we want is universal coverage, then what we are essentially saying is we are not trying to maximize health, we are trying to maximize something

else and what that something else, I think, is an interesting question.

LARRY LEVITT: Sherry, let me bring you in. Keying off of Michael's last point, is expanding health insurance the right aim here?

SHERRY GLIED, PH.D.: I think expanding health insurance is the right aim, but I'm not sure that expanding health insurance is necessarily the best way to improve health outcomes. If that were the only thing we were looking for there are many different strategies that would be good to follow, but I think expanding health insurance brings with it a bunch of other benefits besides improving health outcomes that we might care about.

LARRY LEVITT: A mandate on the scales of let's say Len talked about is unprecedented, at least in the health insurance realm in the U.S., but you've looked at what some other countries have done, let's say the Netherlands and Switzerland, what are some of the experiences of what the process they've gone through and the results they've achieved for the debate here?

SHERRY GLIED, PH.D.: Well, I think what's striking and I think there are many lessons we can learn from the Netherlands and Switzerland. I think the first thing is that they started off with very high levels of coverage before they implanted any sort of mandate. So the mandate was not the tool

that got them from 85-percent coverage to 100-percent, it was a tool that came into play when they were already at about 95, 96, 97-percent coverage. And in fact, interestingly, neither country has done much to actually enforce the mandate so far, although it already appears to have had an effect on coverage. So I think there is a certain, sort of effect of simply saying that it is a mandate, without actually, the cost benefit analysis being done by the individual person, it says something about prioritization and I think that can be helpful.

LARRY LEVITT: So in other words, some people actually followed the rules even if you don't have penalties to make them follow the rules.

SHERRY GLIED, PH.D.: Well one of the things that strikes me in the debate about mandates is that people think of it as, either making a cost benefit calculation or kind of ornery people, libertarians, who just don't approve of mandates. I'm actually struck by people, I think of as negligent procrastinators. It's not that they don't want to comply with the mandate, it's not that they've done the cost benefit calculation, it's just that they have big pile of stuff on their in mail box and they haven't done anything with any of it.

And one of the things that mandates might help us achieve is to move things up the priority list. At the same time I would note that neither the Netherlands nor Switzerland

has achieved 100-percent coverage. There is clearly still people who have fallen by the way side even with the mandate and the subsidies in place and, you know, it's a question of minimizing the size of that population and not eliminating it all together.

LARRY LEVITT: You also talked about some number of people or some people talking about people making this kind of cost benefit analysis which is certainly a natural way for economists to look at this. You looked at mandates in other realms, outside of healthcare.

SHERRY GLIED, PH.D.: Right.

LARRY LEVITT: If you are assuming that people are making some kind of cost benefit analysis, what are some of the features of mandates that make them work well or make them work poorly?

SHERRY GLIED, PH.D.: Well, I think as in many other areas of mandates and enforcement, it's really important that people think that there's a high probability that they will be caught, which means the enforcement mechanism has to be very systematic, very regular, very routine. It's not a question of making the penalties enormous, if we make the penalties enormous they will never be enforced. No judge is going to throw someone in jail for not having health insurance, it's just not going to happen. The penalties have to be proportionate, but people have to believe that if they don't

buy coverage then within a certain amount of time someone's going to catch up with them.

LARRY LEVITT: And how about the penalties are they just financial in this care or are there other kind of costs that are incurred?

SHERRY GLIED, PH.D.: I think one important aspect of the cost benefit analysis that I think we have to think about is how easy it is and how inexpensive and administratively simple it is to comply with the mandate. If it's complicated and difficult and owners, people will not comply and that's the way the cost benefit calculation will work out. Not only money versus money, but how much difficulty, how simple is it to go along with this mandate.

LARRY LEVITT: Do subsidies figure in, I mean the kind of subsidies Len was talking about figure into that calculation?

SHERRY GLIED, PH.D.: Cleary if people can't afford to buy the coverage they are willing to take a risk that they are going to get caught and pay the penalty. So I think it is very important that the subsidy level be adequate.

LARRY LEVITT: We've gotten tons of e-mails on this topic so we clearly hit a nerve and I want to turn to some of those as well and people watching can also call in to ask questions and just to remind you the number is 1-888-Kaiser-8, 1-888-524-7378. Let me turn to the first e-mail question. It

keys off this issue of what we've been talking about, about free riders, how big this pool of free riders is, what are free riders, what do we think of as free riders and Len, let me bring you back in. This is a question that asks, is there economic data on how many people elect not to have health insurance, but end up bankrupt in medical expenses or with severe injuries, which is maybe a fairly narrowed definition of who the free rider pool is. But let me ask you first the same question that I asked Michael, how do you define this group of free riders who would be outside of the system if not for a mandate?

LEN NICHOLS, PH.D.: Well, I think we want to think about the free rider population distinct from the total problem of uncompensated care being shifted to us. I would consider a free rider someone who has a financial means to afford health insurance as we all think about it and chooses not to buy on a voluntary basis. I would put that at most 20-percent of the population of the uninsured. But I think that the number of people who end up imposing costs on the system is much larger than that. They don't go bankrupt because the hospitals don't end up chasing them down and taking their money. They don't go bankrupt because they shift the cost to the rest of us.

Michael talked about 3-percent of total health spending, but that all gets shifted to private premiums, that's about 10-percent of premium which is pretty much what

reasonable estimates are of what the cost shift really is and it varies by different states. California is higher than Massachusetts and so forth, because they have more uninsured. But the uncompensated care problem is bigger than the free riders. The free rider thing is really, in my view, part of bridging the gap around where we are today to really share responsibility for use of our healthcare resource. It's making people pay their fair share, that's why you want to force them to come in and I would certainly agree with Sherry that we are never going to get to 100-percent, you know, Idaho exists, but I think it's like that we could get in the high 90s and that would minimize the problem so sufficiently that we could then turn to make our health outcomes better.

I would like to just point out, I think there are a great deal of studies on the health impact of health insurance in pseudo medicine, the American Cancer Society makes it abundantly clear, you are diagnosed late if you are not insured, you have a much higher likelihood of dying. Hence pseudo medicine estimates 18,000 people die every year from absence of health insurance which keeps them from getting routine care. So I don't think it's correct to leave the listener with the impression that there's no health benefit from health insurance. Whether or not we could get more health benefit in improving education, it's a very interesting

question, but I think we want to make it clear there's a health gain from health insurance as well.

LARRY LEVITT: I want to continue on in this free rider theme, but I want to give Michael a chance to respond. Do you buy the studies Len refers to in terms of the affects of health insurance?

MICHAEL CANNON, M.A., J.M.: I do and Len raises an important point which is that there is a health benefit to health insurance. My point was different though. It is that, is that worth the cost or could we be getting greater improvements in health if we used the same money in different ways. And a review of the literature that was published in a book by the Urban Institute found that in fact, no, there is no evidence that health insurance is the best way to do that. The health effects of health insurance are very real, a lot of people do die because they don't have health insurance. The Institute of Medicine put that figure at 18,000 people per year. But the Institute of Medicine also estimated that medical errors in hospitals kill 50 to 100,000 people every year. So if we are interested in improving health and saving lives should covering the uninsured be our top priority or should reducing medical errors be our top priority.

We really have to look at what is it that we are trying to achieve and is this the best and most cost effective way to do that.

LARRY LEVITT: Len, let me come back to you in this free rider issue and you mentioned this in terms of uncompensated care that some number of the currently uninsured do end up getting care, it's not all of them, they don't necessarily get all the care that they may need. We got another question along those lines connecting to the mandate whether if there is an individual mandate would we be willing to deny care as a penalty or as an enforcement to people who do not comply with the mandate. Would you go that far in terms of a penalty or enforcement?

LEN NICHOLS, PH.D.: I would not and more importantly health professionals would never go there and that's a good thing. But the question of enforcing the mandate again, is coming back to collecting our fair share from people, making sure they do pay their fair share and their fair share may be very low if they are really low income, but if they are high income they should be required to pay. So the enforcement in my mind would always be proportional as Sherry just said and it would be financial, not deny services.

For example one way you might enforce it is to have families be required to prove or to show schools when they enroll their children if their children are indeed insured. You would not send the child home if mom didn't have coverage certificate for the kid, but you would e-mail the appropriate authorities and say you need to send a letter to this household

and figure out why this kid isn't covered because fundamentally they should be.

LARRY LEVITT: And Sherry, would that kind of denying care for somebody if part of the mandate fall into the category of an excessive penalty?

SHERRY GLIED, PH.D.: Clearly it's not going to happen. There is an old libertarian position, Michael, it's no longer the universal health position, but there are prominent writers who have suggested that the way to solve the problem of the uninsured is simply to deny care to people. It's just not going to happen, whether you think it's a good idea or bad idea, it's an unrealistic one.

LARRY LEVITT: And Michael, you are not that kind of libertarian?

MICHAEL CANNON, M.A., J.M.: If we were willing to deny care to people we wouldn't have a free rider problem, it would just take care of itself, but we are not. And by and large our unwillingness to deny care to people is a good thing. Now it does encourage people to take advantage of that guarantee that we offer and a lot of libertarians suggest maybe what we should do is try to allow states to experiment with different ways of providing that guarantee instead of having one federal law do that.

But, I think by and large it's a good thing and it's a sign that we are a good and decent society that we won't deny

care to people. But, I think that it's an interesting aspect to this question of free rider and universal coverage. We, as a society decide that we won't deny care to people, so we have that preference and we want to express that preference, but we don't want to pay for it. We are insulting that that preference of ours actually costs us money and so we want to force other people to chip in and even if they have objections to buying health insurance or we do things to make it unnecessarily expensive for them.

LARRY LEVITT: Len describes the approach he laid out as shared responsibility and it's certainly been described that way in Massachusetts, in California, not entirely successfully, is that, when you say we are not prepared to pay for it, who is the we? Is it shared responsibility?

MICHAEL CANNON, M.A., J.M.: The people who want to live in a society where we don't deny care to people, I think everyone in this room, probably everyone who is listening to this webcast fits into that category. The question then becomes we have that preference, we are not going to deny care to people who come into an emergency room bleeding, so what do we do about the cost of that. I think there is an element of selfishness if we say we want this preference expressed, but we don't want to pay for it, we want other people to pay for it.

I think that given that it's only about less than 3-percent of the cost of healthcare generally, it's not really that big of price that we are paying.

LARRY LEVITT: In terms of the uncompensated care, the shift?

MICHAEL CANNON, M.A., J.M.: Right. At least not compared to the other problems that we face.

LEN NICHOLS, PH.D.: Can I jump in here? First of all, let me just make it clear, I'm for solving medical errors too, so let's not assume that we only get one shot at the policy bandwagon. But second, it's important to understand that the uncompensated care that we actually record is a reflection of what is shifted to the rest of us, but that does not mean that insurance wouldn't bring much more care to the insured. They get, on average, roughly half of what the rest of us get, we know they get it late, etc., and inefficiently. But, what I'm trying to say is there's a bigger problem here than a 3-percent of health spending, it is the economic cost we bear as a nation from the premature death, from the prolonged illness, from the lost work days, all that stuff.

That same Institute of Medicine study a few years ago concluded that the economic cost that society bears in terms of lost output from all this stuff is roughly equal to, I think at the time in 2001, 65 to 130 billion, today it's probably closer to 90 to 175 billion. Those are dollar figures that are

certainly in the ballpark of what it would cost to cover everyone. We are really talking about stewardship of resources here, not just the moral case of health and those who happen to end up in the hospital and happen to get the care they need and happen to shift the cost to the rest of us.

MICHAEL CANNON, M.A., J.M.: But by the same token, if we lose 2-1/2 to 5 times as many people to medical errors as we do to the uninsured what's the economic cost of that and are we setting our priorities incorrectly because we would get not only more health, but also fewer economic losses if we were to solve that problem first.

LEN NICHOLS, PH.D.: But, I don't think it's an either/or, I think you can do both simultaneously, in fact I think you have to do both simultaneously to make the system better.

LARRY LEVITT: Sherry?

SHERRY GLIED, PH.D.: It's also important to realize that you can only go after the problems you know how to solve. And while I would love to end medical errors, no one has got a clue about how to do that. So, whereas covering the uninsured whether through taxes or other mandates or something, we have a fairly good idea of how to do it if we don't have the money for it. But getting rid of medical errors is the subject of another Kaiser Family Foundation Ask The Experts panel and I don't think we really know how to do it.

MICHAEL CANNON, M.A., J.M.: I think that there are things that can be done and group organizations like Kaiser are doing a lot in that area. The Veterans Administration with the data they are collecting, they are reducing a lot of medical errors. I think that there are a number of components or a number of approaches that would help to reduce medical errors and some of them are being undertaken right now, but what's interesting is that a lot of those efforts are resisted by the industry because reducing medical errors and reducing unnecessary care for that matter, cuts into earnings for a lot of members of the industry.

And so one of the ironies of covering the uninsured is there will be more people who are covered. We will also spend a lot more money on medical care and in so far as we are increasing the earnings of the industry, we are increasing their ability to fight these much larger problems that we face and that doesn't—

SHERRY GLIED, PH.D.: Maybe we should make a deal with them, we'll cover the uninsured if you'll take a cut on the medical insurance.

MICHAEL CANNON, M.A., J.M.: Well, you know what, that would probably be an improvement, it would be a tough bargain to strike.

LARRY LEVITT: I think we'll end this with everyone agreeing that we should deal with medical errors at a minimum.

I want to come back to the topic at hand and focus a little bit on some of the design aspects of an individual mandate and some of the tradeoffs that might require. We've got, actually a number of questions about the benefits that a required package would include and mandating something requires you to decide what those are. They actually came sort of across the spectrum. One set of e-mails talking about if a mandate required someone to have a plan with a $1000 deductible that's way too high in terms of out of pocket cost for people to afford. On the other hand how can a mandate work when there are all these state insurance mandates that require more comprehensive coverage. Len, let me start with you as the proponent. How do you think about that tradeoff? What is the kind of minimum level of benefits, or how do we think about the minimum level of benefits that people would be mandated to have?

LEN NICHOLS, PH.D.: First of all I would certainly say that ultimately that is a political, social values question. And my observation in our nation is that views of that vary with geography and obviously economic and social conditions have a place. So Massachusetts will have a very different view about what's minimally acceptable than Utah, for example. In my ideal world, that's okay. I think you would allow a fair bit of flexibility. You probably would want a minimum national floor, but that minimum national floor might be something that

would be tagged probably to the federal employees thing, not to necessarily have that, but to say that's a standard we can all count and agree on and compute the value of. You might say 80-percent of that and then you allow the private insurance industry to come up with different packages to meet that actual value target and then you allow maybe, if congress agrees and so forth, and people think that's smart, you allow different states to move that thing up or down. To me that's a much smarter way to let local values and abilities to pay reflect in the policy design.

The tradeoff you face, which is fairly severe, is the more generous you are in demanding that the package cover XYZ, the greater your subsidy costs are going to have to be and the higher up the income scale you are going to have subsidize people to make it truly affordable. So what I tend to think of is requiring a parsimonious package, but make that parsimonious package decent and make the cost sharing that goes with it, it's got to be considered as well. You don't want to have this, because as the e-mailer suggested, you don't to have poor people facing really high cost otherwise you defeat the whole purpose. But, you don't want to go too high up the income scale so you want to think about what is the package I would require someone to buy that would give clinical value that they should be able to buy unsubsidized. That's the way to think about the package.

LARRY LEVITT: And Sherry, does that sound right to you? How do you think about this?

SHERRY GLIED, PH.D.: I think there are different pieces of this package that we could imagine. One is the piece that has to do with the free rider problem and I think it's not only, and Len alluded to this at the beginning, I don't think it's simply the fact that people are free rider on emergency rooms or whatever, I think it also has an effect on the way the individual market functions all together that some people are not in it and it has an effect on how the sales of insurance have to work. If everyone is buying coverage and the choice is which plan, that's a different market than one in which some people have to be persuaded that they want to buy coverage in the first place. I think there's that whole component that we want to think about and that is something that we think everybody ought to do because it's their civic responsibility, we are already paying for them one way or another.

If we want to make the package more generous than that, we are basically telling people that they are going to have to spend their own money in a way that we think is right for them because of other reasons. There, I think that it is only appropriate for us to do that if we are willing to pay the taxes to make it possible. So I think from a pure free rider perspective, a fairly high deductible, fair parsimonious plan that didn't actually have much in it at all, would be kind of

the piece that fits with this. And then you'd engage people with the market and let them pick whatever they like. If you want them to have more coverage because it could provide health benefits or whatever, you better be prepared to pay the subsidies.

LARRY LEVITT: Let me start with the first thing you talked about in terms of making the market work and Len certainly referred to this earlier. If you could take a second to explain why, let's say an individual mandate might be necessary in order to make an insurance market, a non-group insurance market in particular work?

SHERRY GLIED, PH.D.: I think there's a couple things we know. One is employer sponsored insurance is way cheaper than individual insurance. And you ask yourself, well why is that the case. I think there are two reasons that it's the case that are important to keep in mind. First of all, the selling costs are trivially small in the employer market. Once your employer has signed on, it cost very little for you to sign up anymore. It's right in your face, so there's no selling cost at that point. Second, there's a naturally formed group in which even healthy people are forced to participate. The individual market has neither of those features. Every person has to be sold their coverage and they have to persuade to maintain their coverage and so the selling cost is very high and moreover if you are very healthy and coverage costs go up,

you are likely to drop out. So, I think one of the pros of a mandate is to say we are going to take those two things off the table. And I think that's part of the reason interestingly that other countries that run universal systems with a lot of different health insurance plans, a lot of sickness funds or whatever, have much lower administrative costs than we do, despite having a multitude of plans because although they have many plans the plans don't have to actually sell coverage, they just have to compete amongst themselves for who gets this person.

LARRY LEVITT: And Michael is the use of the mandate in order to make the insurance market, the non-group insurance market function, is that a persuasive argument for you?

MICHAEL CANNON, M.A., J.M.: No, but there's a point that you were discussing before that I wanted to comment on, it has to do with defining what we are mandating. If you require a certain behavior on the part of the citizenry, you have to tell them what that is, so you have to buy insurance, you have to tell them what insurance means. And it would be nice for we, philosopher kings, Sherry and Len and me and you to come up with a reasonable definition of what insurance package is going to look like and we could all agree on it and there would be some fairness to it, but we don't control these things. The people who are going to control what goes into that package are members of congress and the special interest groups, the

providers who will benefit financially from having a broader package.

We see in this in the state level when there isn't a mandate to buy insurance. Providers go to the legislature and they say, we want these services covered, we want our services covered, the chiropractors and others say we want our services covered because that expands the market for their services and increases their incomes. And we can expect to see the same thing happen at the federal level even if congress begins with a very low minimum the pressure is going to be there to increase the amount of coverage and that's going to make the mandate that much harder to comply with, so there's that.

So I think that it's important to keep in mind that that is a dynamic that is going to take over any definition of what is covered in the mandate and in fact, one thing that happened in Massachusetts was, a lot of people who had coverage, as far as we know very happy with, we are told by the Commonwealth that the coverage that you have is not comprehensive enough. You have to buy more coverage in order to satisfy the mandate. So even though preferences vary by geography including from your house to your neighbor's house, those preferences are going to be overruled by any mandate.

Now about using mandates or other rules to make individual markets work, I think that the non-group health insurance market doesn't get enough respect and the reason is

is that research by Mark Polley and his colleagues from the University of Pennsylvania and by scholars at Brand, find that there's a lot of pooling that happens in the individual insurance market. Sherry identified one of the problems which is over time there are incentives for that pooling to maybe unravel and Kaiser has done some work on that. But you have to ask, compared to what. In the employer based market there are a lot of risks that don't get pooled, the risks that you are going to lose your job and lose your coverage when that happens. Other risk is your employer isn't going to offer coverage. So I think there's a lot of pooling that happens in the individual market.

We have to recognize that and true the administrative costs are much higher in the individual market, but I think that with a level playing field between the two, group and non-group coverage the administrative costs would probably fall in a thicker individual market.

LARRY LEVITT: Sherry, let me bring you back in. First of all sticking to the topic of the individual market, what do you make of let's say Mark Polley's arguments that there is a substantial amount of pooling that does now happen and is that sufficient?

SHERRY GLIED, PH.D.: The individual market is a residual market in almost all places in the United States. Most people who are in it are in it for a very brief time. So

it's a little hard to know exactly in large data sets how much pooling is going on. I mean, I think Mark's work is good, but we are not actually observing people over any lengthy period of time and we don't really know.

As to the question of whether administrative costs would fall, we've actually looked at places and states in which the individual market is relatively thick and we don't find any real advantages in terms of premiums in those places compared to places where the market is thinner. So if you look at some of the Midwestern states where the individual market is historically richer, thicker, has a lot more people in it, they don't actually have lower premiums even though there are more people in the market. The inherent costs are just there and one thing that we might hope with the mandate is that we could bring those costs down and make that market more inherently competitive.

LEN NICHOLS, PH.D.: If I could just jump in since I'm the only person that's actually written a paper with Mark Polley on these questions, we jointly published a paper about the individual market a few years ago. I think what we concluded was very clear, it does work for some people, maybe even a majority of the human beings, but it doesn't work and it can never work as it's currently constructed for the people who have health conditions who are the ones in most need of health insurance for the simple reason that the insurers who sell,

they are not charities, they can't be expected to subsidize those kinds of risks out of their own profit. So they are going to always try to figure out a way to restrict the sixth access to their product. So a mandate alone won't even solve the problem, you've got to change the way the rating happens, you've got to have the rules and what I'm trying to say is that mandate enables you to change the rules in a way that maintains a viable business proposition for the insurance companies.

But I will say the fundamental trust and goal and indeed dream of those of us who advocate mandates and advocate trying to actually get most Americans, if not all, covered is to turn that insurance value proposition from risk selection which will always work for the healthy who, thank god are most of us at any given day, but to turn the value proposition from risk selection into delivering clinical value per dollar and let's increase value per dollar.

It's interesting the companies that actually see how they could manage care and do a better job of selecting providers are using the right protocols, etc., to get more clinical value per dollar, those people are perfectly comfortable and those are the ones with the mandate and with the rules that we are talking about. Those are the ones that supported, for example, the reforms in California, Kaiser, Blue Shield of California, and Health Net and so forth. The ones who opposed these kinds of rules are the people who only make

money selecting risk, they are the ones for whom the business model they are in is in my view antiquated and needs to be erased. They should sell their book of business to those people who can manage care or they should learn to do it themselves, but we stop the child labor, we stopped slavery, we ought to stop extreme mis-selection too.

LARRY LEVITT: Michael?

MICHAEL CANNON, M.A., J.M.: What Len said about insurers not offering coverage or the individual market not covering people with high cost conditions is correct, but with this one caveat, they don't cover high cost conditions if you show up and try to purchase health insurance when you have a high cost condition. Obviously they are not charities, they can't do that. But if you buy insurance when you are healthy and you develop a high cost condition, then you get to keep the insurance that you have. It does appear that they are covering people, a lot of people with high cost conditions and really when you think about it, that is the market's way of preventing people from being free riders, from waiting until they have a high cost condition and then buying health insurance instead of paying money into that pool all along so that you can help others who need the help. If the market allowed people to wait until they were sick, then they would essentially be allowing them to free ride.

LEN NICHOLS, PH.D.: And a mandate would be the simplest way to solve that whole problem.

LARRY LEVITT: Isn't that the problem with the mandate?

MICHAEL CANNON, M.A., J.M.: In so far you get people to purchase insurance, yes, it solves that free rider problem, it doesn't solve the entire free rider problem and again the free rider problem, I don't think is that big, but you also create all sorts of other problems and one of them is healthcare spending is going to explode for a number of reasons, one of which is, I mentioned, the influence the providers are going to have on the minimum benefits package. But also most of, and I think Len has mentioned adding community rating or price controls on health insurance to sort of level premiums between healthy and sick, the problem with those laws is they increase the amount of insurance that sicker people purchase and lead to more consumption which increases healthcare spending overall.

So while we are trying to solve the 3-percent problem we are going to make our 30-percent problem of waste in our system that much worse.

LARRY LEVITT: I want to come back to price controls because we actually have some e-mails about that, but Len let me just come back to you to close this out. If you could describe what you have in mind for the kinds of rating reforms you would imagine in a mandated system.

LEN NICHOLS, PH.D.: Well, I would certainly think there's got to be guaranteed issue, you have to sell to all commerce, you would probably restrict the variance in premium across individuals. Peer rating is a goal of some people, it's not mine, I've ready Mark Polley's early work I understand it's probably better and smarter than insurance people that I know in real life, all feel fairly comfortable with age rating as a good proxy for allowing it to breath and basically trying to minimize what you require the healthy, young immortals to have to pay. But, don't allow health status rating so you remove the incentive to do the underwriting which is what drives up the cost of insurance in the individual market and that's why Sherry's result, that there's no real difference across states where it's bigger or larger, it's all because of the rating they are doing now, the underwriting they are doing now. So age rating, guaranteed issue and guaranteed renewal and so forth.

LARRY LEVITT: I do want to come back to this issue of price control since Michael brought it up and we have had several e-mails on it. I'll read one, in order for any healthcare proposal to work doesn't there have to be some sort of cap or maximum on the rising cost of healthcare. And this is an issue that's come up in the debate in California as well that if we are going to mandate people into a private insurance then should the government play a role in regulating the

premiums that the private insurers are paying since it's now a mandatory product. Sherry let me let you answer that how you ever want, but I'm particularly interested in you're looking at some of the other countries like Netherlands and Switzerland, or other realms where there are mandates, is it paired with some kind of government regulation of what those insurers can charge?

SHERRY GLIED, PH.D.: I think in some cases it is, but in many cases it's not. So I don't think that there is a uniform answer to that question. I think that the key here and I guess it goes back to the point that Michael made right at the very beginning is that if we want to provide coverage to people the government is going to have to force somebody to do something that they didn't want to do at some point. They are either going to have to force them to pay taxes that they didn't want to pay or force us to pay for our own coverage through a mandate. And I think the real danger with a mandate that people are aware of is that we might mandate people to buy things that they can't then afford and we might become the tyrants than Len describes simply by inadvertent or being budget conscious or whatever.

And so I think that the trick is not so much controlling the prices, because I think that's not going to work in the long run, we know it doesn't work in the long run, we have no really good ways to do it, the trick is making sure

that the subsidies and the mandate are interlinked in a way that really holds. Making the mandate contingent on the subsidy for example would I think satisfy me on that account. And I think would probably help the legislatures to combat the provider pressure that at this point has no counterpart in most of the state budget discussions. So I think that's really where the price containment piece has to go in. It has to go in on the level of we are not going to expand the benefits, we are not going to do all this good stuff, because we, the legislature are going to have to pay for it in the subsidy money.

I don't think that containing the cost, I mean we've seen it in car insurance, so we have car insurance mandates and some states go and try and legislate the price of car insurance, it doesn't really work very well in the long run.

LARRY LEVITT: Let me also, not in related to this, we've also gotten many e-mails on a topic of a single payer system and I don't feel like I can leave the hour without asking about it and I'll read one of them. Instead of requiring individuals to purchase individual coverage that they truly can't afford, wouldn't it be better to establish a single universal risk pool equitably funded based on ability to pay? Michael let me start with you, not that I'm assuming because you are an advocate of single payer, but in your view what is

the difference between an individual mandate for private insurance and a single payer system?

MICHAEL CANNON, M.A., J.M.: Well not much and the reason for that is, in the single payer system, the government taxes takes your money and then it gives you the healthcare, it tells you want kind of healthcare you are going to get. In a system with an individual mandate the government lets you keep your money, but it tells you how to spend it and tells you want to spend it on and what kind of healthcare you are going to get. So, who makes the decisions doesn't change, it's still the government making the decisions. I think the difference has to do with, and this might explain while a lot of the left prefers single payer, the difference is that it's administered by private companies who are going to be making a lot of money off the tax payers, who are going to be able to lobby the government for policies that are going to increase their earnings and that's a reason why I oppose individual mandate as well. I just oppose it and would rather see us move in the opposite direction of the government taking less of your money and letting workers decide what to spend their money on rather than mandates.

LARRY LEVITT: And Len, let me ask you the same question, what in your mind are let's say the similarities between an individual mandate and a single payer system and what are the important differences in your mind?

LEN NICHOLS, PH.D.: Well, it's really interesting in the way the e-mailer or the caller put it in the language was they would rather have a sliding scale where basically payment was based on the ability to pay and they think that's only achievable in a single payer system. I think that's achievable in the individual mandate system and we could do it all with private markets. I think fundamentally the issue about what the differences are have to do with on the supply side, the financing, is not going to look that different whether it's a blue card, or a green card, or a red card.

The supply side is where it really matters. A single payer system turns physicians, clinicians, into employees of the government and Michael's right, that would give the government far more control over what actually happened, where as an individual based market system would allow a lot of creativity, innovation to occur and lord knows there's waste out there now and we want to do a whole lot better about buying smarter and reducing that waste, but I would fear the price control temptation would be too great with a single payer system, at least in the short run until we get far better at buying smarter. So I would rather have the system breath and be a little inefficient frankly, but preserve the choice that I think most Americans and certainly most clinicians would feel more comfortable with.

I think in the long run a single payer system would lower administrative costs at the expense of creativity innovation in product and in service delivery and in the short run the private system would give you more of that, but it's going to cost more.

LARRY LEVITT: Michael, do you want to respond?

MICHAEL CANNON, M.A., J.M.: No, I'll pass.

SHERRY GLIED, PH.D.: I don't know, relative to a bicycle, a mini Cooper and a Hummer are both cars, but that doesn't mean that if you were in the market for a car a mini Cooper and a Hummer would look the same, so I'm not convinced that a single payer system and an individual mandate really translate into the same thing. But I think that devil is in the details. The question is how we design the mandate, who is subject to the mandate, where the mandate level is going to be set and what the politics of that are likely to be and my guess is the politics of a mandate are likely to set the mandate somewhere around, even if the provider groups are as powerful as you'd like them to be, the 30th or 40th percentile of the health insurance distribution like that.

LARRY LEVITT: So that means, let's say 30-percent of people have coverage that's less comprehensive today and 70-percent of more comprehensive.

SHERRY GLIED, PH.D.: …have coverage that is more comprehensive. Because everyone knows that the subsidies have

to come out of their pockets, that means that at least 70-percent of the insured population is going to be in a very different environment than a single payer system. So, would it be better to go to a single payer system, it's a long debate. We could talk about that in another session as well. But the idea that these are the same things, I think is misleading.

LARRY LEVITT: And how about on the financing side, Len talked about the potential for an individual mandate system to move towards a more progressive financing structure like most single payer systems.

SHERRY GLIED, PH.D.: I think one of the mistakes we make in this country is to believe that healthcare reform is something that you do once. Countries that have actually done it realize that it's something that you do every three years and that is going to be the case no matter how we move forward here. So, which way we'll go, I can't say. We'd have to take the first step first.

LEN NICHOLS, PH.D.: I would also say if you look at the subsidy schedule put in place in Massachusetts, you look at the one proposed in California and you look at the one proposed in congress right now, the one concrete proposal that has bipartisan support is the Widen/Bennet Bill. There you see progressive subsidy structures, maybe not ideal, I certainly agree with Sherry, we would revisit not every three years, every year we will be talking about something on it. You can

certainly begin and tweak it to fit your preferences over time, how progressive you want it to be.

MICHAEL CANNON, M.A., J.M.: I think it's important, every policy we talk about we should be considering tradeoffs involved and I think an interesting tradeoff involved with the progressive subsidy scale is that those sorts of subsidies that disappear as your income increases or gets smaller and eventually disappears as your income increases, they created this incentive for you to earn and increase your income. So if you look at all of the programs that are available to a single mother of two living in New Mexico and that includes Medicaid, SCHIP, housing subsidies, childcare subsidies, and food stamps and so on, and say that single mother of two is making $15,000 a year. If by some miracle she is able to increase her earnings from $15,000 a year to $45,000 a year, effectively triple them, you would think that she would be better off because she would have $30,000 of additional earnings. In fact, she would be no better off financially because she would lose $4000 to taxes and then she would lose $26,000 of government benefits. So her marginal affect of tax rate is 100-percent and she has very little financial incentive to climb the economic ladder.

If we layer even more sliding scale subsidies on to that then we are going to be creating even more substantial disincentives for people to climb the economic ladder.

LEN NICHOLS, PH.D.: I would say, though, a big piece of that difference and I agree with Michael's math at the moment, is the Medicaid benefits which she has access now which she would lose that's because right now it's a binary thing, you either go off the cliff and lose it completely or you have it completely a sliding scale like we are all talking about would significantly reduce the contribution of disincentive of the health insurance scheme we are talking about.

MICHAEL CANNON, M.A., J.M.: Actually, I have to disagree with you there Len because it would not. If the subsidy disappears—

LEN NICHOLS, PH.D.: We can talk about economics later, maybe.

MICHAEL CANNON, M.A., J.M.: If the subsidy disappears as a result of her increasing her earnings then you can spread out that disincentive and that's why I actually picked a very long window from $15,000 to $45,000 per year. That disincentive always exists and you can't erase it with a phase out period. You can extend it and will become more expensive.

SHERRY GLIED, PH.D.: I don't know, I employ janitors and if I offered them a triple salary increase, even though they would lose a bunch of a benefits, I can't imagine anyone turning this down. We can write about these disincentives and we can model the disincentives, but the actual impact, when people look at it, John Gruber has done some nice work on this

and the economic impact of phase out disincentives on people's behavior is very small. It's not something we should be losing sleep over. We should do what's fair and right and try and think it through as best as we can, but the alternative is just to leave everyone on their own, because that's what gives you the strongest incentives and I don't think that would be a fair society in which to live.

LARRY LEVITT: We are pushing the end of the hour so I want to turn to a couple final questions and while we are on the question of mandates, we also got questions on not just an individual mandate, but an employer mandate which also could be a topic for another show. But Len, I just wanted to turn to you as the proponent on the panel of individual mandates, how do you see an employer requirement fitting in here?

LEN NICHOLS, PH.D.: Well, when I think of the 21st century economy as an economist, as opposed to a health policy analyst, I think we need to figure out a way to reduce our reliance on the employer financing. It can't be done over night, it's going to have to be a transition, but I'm really worried about international competitiveness and I think we all should be. So I would not like to see new requirements being imposed on employers. It's interesting that a number of different organizations have embraced individual mandates and approach and willingness to tax ourselves to have subsidies and they range from the National Business Group on Health this

morning to the Arista Industry Committee, Federation of American Hospitals, the Colorado Business Forum. I'm here in Colorado because a number of business leaders have joined others to advocate covering all Coloradoans with individual mandate here tomorrow, but they all oppose requiring employers to pay more.

It's not necessary, it's fundamentally a financing question and when you think about the employers who voluntarily provide it today basically would be expected to continue doing it in a new regime. The ones who don't provide it today are pretty much low wage firms. Taxing low wage firms first of all there's not a whole lot of money there and second you end up taxing low wage workers. I'm not sure that's the smartest way to expand coverage. So for my money it's smarter to come up with alternative financing schemes, but for a lot of people it is the simplest one and for some people it's a concept of gross fairness to require employers to "pay their fair share" as well. It's not my preferred option; I could live with it if that's what congress thinks we have to do.

LARRY LEVITT: Speaking of congress, I'm going to wrap up the hour with a final question from an e-mailer in Washington which is, if we look at the case of the mandate in Massachusetts as a case study, what caveat should we be aware of in terms of how similar health reform package would play out on a national level. I want to give each of you an opportunity

to think about this real life experiment in Massachusetts and what some of the lessons of that experience, both the passage of the bill, the implementation of the bill mean for a potential similar debate nationally. Michael let me start with you.

MICHAEL CANNON, M.A., J.M.: Lessons to be drawn from Massachusetts, I think there are a number of them. One, an individual mandate won't cover everyone. Number two, we you pass an individual mandate there's going to be a lot of rent seeking by employers, but also mainly by providers to increase the amount of coverage that people have to purchase because that increases the providers' incomes. Three, we didn't in Massachusetts get this kind of reform until Massachusetts faced the prospect of losing federal funds. So what that means is it even speaks more to the point that the body politic, at least in Massachusetts didn't have the appetite for coming up with the subsidies necessary to achieve universal coverage. It was only because there was 380 million dollars that the feds were going to take away that they were able to pass this and then finally, in the wake of California because the reform efforts appear to have failed there, a lot of people are saying well the federal government has to take over and reform health care.

I think there's a lesson to be learned on that question from Massachusetts which is because that money, that 380 million dollars and a possible loss of that money was really

the impedes for enacting this reform, it shows the danger of having the federal government provide those subsidies and most people want to do that because the feds don't have to balance their budget. And what that really means is that I think Massachusetts highlights the danger that we might try to achieve some large scale healthcare reform by deficit spending at the federal level which is a way of getting around the body politics resistance to higher taxes that would be involved by pushing those taxes off onto future generations. So I think there's that danger as well.

LARRY LEVITT: Sherry.

SHERRY GLIED, PH.D.: Well, if it's only 380 million dollars, that's really cheap, we could get universal coverage in America for 20 billion, right, if I multiply correctly. If that's all the federal money that it takes to make all the states move it would be a lovely outcome.

MICHAEL CANNON, M.A., J.M.: But it wasn't.

SHERRY GLIED, PH.D.: Well, I do think that that does suggest that moving ahead through some mixture of federal and state action is probably the best way to go and that may be the lesson in Massachusetts. There's a lot of diversity in the country, the federal government certainly has a role, but whether the role is to run the whole system or whether the role is to enable reform at different levels, whether through

deficit spending or bribery is a question. I think we have to watch Massachusetts before we can learn lessons.

LARRY LEVITT: And Len, you get the final word here.

LEN NICHOLS, PH.D.: Okay, well first I would say over 300,000 people have coverage that didn't have it last year and most people in Massachusetts have been surprised at how many signed up and I happen to have been at a dinner with the former lieutenant governor who was a big fan of Mitt Romney and thinks it's a great success as well as I know John McDonough who is a strong advocate for healthcare for all of Massachusetts thinks it's a great success, so you've got a pretty wide spectrum of folks in Massachusetts who thinks it is a success. It's not perfect, we are going to have to fix various dimensions of it, et cetera; but lessons for the larger country's debate I would submit are two. One, you had a bipartisan agreement, you had a republican presidential aspirants willing to use the word all, a democratic legislature, a very liberal one, willing to accept the word limit. Out of that combination you can make a compromise to work.

And then the bigger one, the second one is that I think it's unambiguously true that we have to think about this as a society, we are one community and one community may decide we are willing to spend this much this year and then we'll look at the facts and decide how much we are willing to spend next year. They'll have to continually revisit the subsidy

structure and the amount of money they are offering to pay for it and Michael's right, we have to be mindful of the long run cost of this, but that's precisely why you want to do delivery system form and get those errors out and get the waste out simultaneously with expanding coverage so we can make it sustainable for us all.

MICHAEL CANNON, M.A., J.M.: So the package should have that included in it. I have you on record.

LEN NICHOLS, PH.D.: Everything you see me write Michael, we'll always have it there and by the way, most candidates have it there too.

LARRY LEVITT: We end on a note of consensus. I'm Larry Levitt and you've been watching KaiserNetwork.org. Thanks to our panel of experts and thinks to you for joining us, we'll see you next time for Ask the Experts.

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